

**QUALITY MANAGEMENT (QM) ACTIVITIES WHICH CAN
GENERATE CONFIDENTIAL DOCUMENTS**

1 PURPOSE: This change to Veterans Health Administration (VHA) Directive 98-016 adds an additional type of quality assurance focused review for which documents generated will be confidential under Title 38 United States Code (U.S.C.) Section 5705 and its revised implementing regulations, dated October 24, 1994.

2. POLICY: Only VHA documents which meet the requirements in 38 U.S.C. 5705 and its revised confidentiality regulations will be confidential.

3. ACTION: The following paragraph is added as paragraph 4.b.(2)(d):

(d) Root Cause Analysis

1. Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse clinical events or close calls. A Root Cause Analysis investigates events and activities, gathers and manipulates data, and examines and reviews VHA care delivery activities in order to:

a. Identify the system elements or components that cause or contribute to the occurrence of an adverse clinical event or close call; and

b. Develop corrective actions and procedures for VHA to adopt both locally and nationally that will prevent the recurrence of similar events or close calls.

2. Root Cause Analysis usually involves:

a. The gathering and examination of patient-specific and provider-specific data.

b. Analysis and coordination at and between the facility, VISN and national levels.

3. Root Cause Analysis includes reviews of several similar events such as medication errors to derive common causal factors and solutions, and is commonly referred to as an aggregated review.

4. FOLLOW-UP RESPONSIBILITIES: The Chief, Office of Performance and Quality (10Q) is responsible for the contents of this Directive.

5. RESCISSION: VHA Directive 98-016 and change 1 expire March 12, 2003.

S/ by M.L. Murphy for
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Acting Under Secretary for Health

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THIS VHA DIRECTIVE EXPIRES MARCH 12, 2003